Excellus

P.O. Box 22999, Rochester, NY 14692
A nonprofit independent licensee of the BlueCross BlueShield Association

Monroe County
GROUP ENROLLMENT FORM

DO NOT USE - INTERNAL PURPOSES ONLY

Instructions on last page. All Dates = mm/dd/yy

PLEASE PRINT CLEARLY

1 – Group Employer Information

This section should be completed by the Group Benefits Administrator.
This application cannot be processed without this information and a signature.

Please use blue or black ink, print one character per box

Group #: 0 0 0 0 9 3 7 0
Subgroup #: ☐☐☐☐
Class#: ☐☐☐☐

Employer Name: **Monroe County**

District: **N/A**

Group Administrator Signature/Date: **X**

Subscriber Status:
☐ Active ☐ Retired ☐ COBRA ☐ Cancelled

Please indicate reason for COBRA:
☐ Left Employ/Retirement
☐ Death of Spouse
☐ Divorce/Legal Separation
☐ Dependent Reached Max Age
☐ Loss of Student Status
☐ Other ___________________

Effective Date: ☐☐☐☐☐☐
COBRA Effective Date: ☐☐☐☐☐☐

Hire/Rehire Date: ☐☐☐☐☐☐
Retired Effective Date: ☐☐☐☐☐☐

Dental Group # [redacted] Subgroup # [redacted] Pkg # [redacted]

Was the employee subject to a waiting period before enrolling in your employer health plan? ☐ No ☐ Yes

If yes, what was the start date: ☐☐☐☐☐☐ and end date ☐☐☐☐☐☐

2 – Subscriber Plan Selection

Department # [redacted] Employee # [redacted]

Please use blue or black ink, print one character per box. Check applicable plan(s).

Blue Point 2
- ☐ Value (DK)
- ☐ Select 1 (DH)
- ☐ Select 2 (DF)
- ☐ Extended 2 - Retiree (EF)
- ☐ Extended 1 - Retiree (EG)
- ☐ Value - Retiree (DL)
- ☐ Select 1 - Retiree (DI)
- ☐ Select 2 - Retiree (DG)

HealthyBlue
- ☐ Copay Option (A2)
- ☐ HSA (CL)
- ☐ HSA - Retiree (C1)
- ☐ Copay Option - Retiree (CM)

Please check coverage type and person(s) to be covered:
Medical: ☐ single ☐ sub & spouse ☐ sub & dependent(s) ☐ family
Dental: ■ single ■ sub & spouse ■ sub & dependent(s) ■ family

3 – Reason for Enrollment/Change

Subscriber, please indicate the reason for this enrollment or change.

☐ New Hire ☐ COBRA ☐ Retirement ☐ Loss of Coverage ■ Domestic Partner
☐ Open Enrollment ☐ Address/Phone Number ☐ Last Name ☐ Age 65+ ☐ Remove Dependent ☐ Change in Student Status
☐ Medicare Eligible / Please indicate reason for Medicare eligibility: ☐ Newborn ☐ Disability ☐ End Stage Renal Disease
☐ Add Dependent / Please indicate reason for adding dependent: ☐ Adoption ☐ Marriage ☐ Marital Status Change

4 – Subscriber Information

Please complete both sides of this application.
The subscriber signature is required in order to process the application.

Subscriber's Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Subscriber's First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Middle Initial: ☐
Title: ☐☐☐
E-mail Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Primary Care Physician's Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Primary Care Physician's First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Ob/Gyn's Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Ob/Gyn's First Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Are you a Previous Patient of PCP? ☐ Yes ☐ No
Are you a Previous Patient of Ob/Gyn? ☐ Yes ☐ No

Mailing Address: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Apt or Suite: ☐☐☐☐☐☐

City State Zip

Work Phone Number Home Phone Number Cell Phone Number

Date of Birth Gender Social Security Number

Gender: M F

Marital Status: Single Married Legally Separated Divorced/ Marital Status Event Date

Medicare Number (if applicable) Part A Effective Date Part B Effective Date

If Medicare eligible due to ESRD please check type of dialysis: Self administered Facilitated Date started

5 – Other Coverage Information

Have you ever been a member of Excellus BlueCross BlueShield? Yes No

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

Have you, your spouse or any enrolled dependent had other coverage within the last 63 days? Health? No Yes / Dental? No Yes

If answering "Yes", are you keeping the additional health and/or dental coverage? Health? No Yes / Dental? No Yes

Who did the other plan cover? Self Spouse Children

Other insurance carrier name:

Other insurance name of policyholder:

Policy ID Number: Effective Date Termination Date

6 – Cancellation Information

Please indicate who is being cancelled and the reason for cancellation (reason listing on page 4).

Subscriber Medical Dental / Reason_____ Date

Dependent (list each dependent in section 7) Medical Dental / Reason _____ Date

7 – Dependent Information

Please provide all information for each person to be covered.

Subscriber's Last Name Subscriber's First Name

Spouse/Domestic Partner Last Name Spouse/Domestic Partner First Name M.I.

Primary Care Physician's Last Name Primary Care Physician's First Name

Ob/Gyn's Last Name Ob/Gyn's First Name

Are you a Previous Patient of PCP? Yes No

Are you a Previous Patient of Ob/Gyn? Yes No

Male Female Date of Birth Social Security Number

Are you enrolling as a Domestic Partner? Yes No

Medicare Number (if applicable) Part A Effective Date Part B Effective Date

8 – Release/Signature

Subscriber signature required. You must sign and date this form to be eligible for insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature_____**Date**_____

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9 – Additional Dependents

Please provide all information for each person to be covered.

Subscriber's Last Name | Subscriber's First Name

Dependent's Last Name | Dependent's First Name | M.I.

Primary Care Physician's Last Name | Primary Care Physician's First Name

Ob/Gyn's Last Name | Ob/Gyn's First Name

Are you a Previous Patient of PCP? ☐ Yes ☐ No

Are you a Previous Patient of Ob/Gyn? ☐ Yes ☐ No

☐ Male ☐ Female Date of Birth

Social Security Number

Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

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Dependent's Last Name | Dependent's First Name | M.I.

Primary Care Physician's Last Name | Primary Care Physician's First Name

Ob/Gyn's Last Name | Ob/Gyn's First Name

Are you a Previous Patient of PCP? ☐ Yes ☐ No

Are you a Previous Patient of Ob/Gyn? ☐ Yes ☐ No

☐ Male ☐ Female Date of Birth

Social Security Number

Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

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Dependent's Last Name | Dependent's First Name | M.I.

Primary Care Physician's Last Name | Primary Care Physician's First Name

Ob/Gyn's Last Name | Ob/Gyn's First Name

Are you a Previous Patient of PCP? ☐ Yes ☐ No

Are you a Previous Patient of Ob/Gyn? ☐ Yes ☐ No

☐ Male ☐ Female Date of Birth

Social Security Number

Is your over-age dependent handicapped or disabled? ☐ Yes ☐ No

(See last page for additional information)

Is Dependent a full time student? ☐ No ☐ Yes If yes, please indicate college/university name:

College/University Name | Expected Graduation Date | Credit hours

Instruction Page

Reason for Enrollment/Change: Check the appropriate action in the space provided. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request **must** be received within 30 days of the event date. Please see your Group Administrator/Representative for events that fall outside the 30-day period. If New Hire, Open Enrollment, Add/Remove Dependent or Loss of Coverage, you **must** also check coverage type and persons to be covered, and Dependent Information section.

Cancel Request
To process a Subscriber or Dependent cancellation, please use the **Membership Cancellation Worksheet - OR -**

To Cancel an Employee/Subscriber using the Group Enrollment Form:

- check Subscriber box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information

Cancel Subscriber Reasons

Left Employer/No Longer Eligible	COBRA End Date
Commercial	Subscriber Request
COBRA Begin Date	Subscriber Deceased
COBRA Handicapped/Disabled Date	Spouse's Insurance
Transfer to Traditional	Medicaid
Transfer to HMO	Medicare
Transfer to POS	

To Cancel a Dependent using the Group Enrollment Form:

- check Dependent box
- check Products to be cancelled (Medical, Dental)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- complete Dependent Name and Dependent Birth date

Cancel Dependent Reasons

Marriage – when permitted by law	COBRA Begin Date
Dependent Over Age	Subscriber Request
Deceased	Divorce
Ineligible Student	Medicare

COVERAGE TYPE All products may not be applicable to your employer group. Please check with your Group Administrator/Representative.

SUBSCRIBER If you or your dependents are Medicare eligible, complete the questions regarding Medicare Coverage.

FAMILY MEMBER INFORMATION If there are more than seven dependents please use an additional form.
QUALIFIED GUIDELINES:

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the eligible child age for your employer group:
  - natural, adopted or stepchild
- Other: Please contact your Group Administrator/Representative for the appropriate form. These dependents have additional eligibility requirements.

  Dependents pending adoption, for whom you are the legal guardian, and/or a handicapped or disabled dependent who is over the dependent age for your employer group.

RELEASE

- I am applying to enroll myself and my eligible dependents, if any, under the medical and/or dental contract.
- In the event that a premium contribution is required of me, I agree to pay the premium amounts applicable to the contract under which I am covered. I authorize my employer to deduct from my payroll such applicable amounts and to remit them to Excellus BlueCross BlueShield.
- If this application is made on behalf of a minor, the responsible party must complete the application.
- By accepting this contract, I grant permission to Excellus BlueCross BlueShield to submit charges to and/or recover payment from any other insurance carrier acting as my primary insurer.
- I authorize Excellus BlueCross BlueShield to request and receive medical or dental information regarding me or my covered dependents from my healthcare practitioner or healthcare institution either orally or in writing and to use this information for providing coverage. Providing coverage includes: processing claims, reviewing grievances or complaints involving care and quality assurance reviews of care, whether based on a specific complaint or a routine audit of randomly selected cases. In the use of data for these purposes, we may transmit personal information to third parties with which we contract, including pharmacy benefit managers, disease management vendors or surveyors.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
- **POINT OF SERVICE (POS)**

  I understand that the Point of Service (POS) coverage is comprised of the HMO in-network product and the BlueCross BlueShield out-of-network product and that I have applied for coverage under both. I understand that the in-network benefit provides the highest level of coverage under the plan.
- **PREFERRED PROVIDER ORGANIZATION (PPO)**

  I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and an out-of-network benefit which provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
- The certificate or contract for which application is being made may impose a waiting period of up to twelve (12) months for preexisting conditions, subject to the provisions of applicable law including creditable coverage requirements. The certificate or contract document will describe any applicable waiting periods.

GROUP EMPLOYER INFORMATION This section to be completed and signed by the Employer Group Administrator/Representative. Complete only the coverage section (Medical/Dental) that is applicable to the employee's request.

If you have any questions, please contact Customer Service at:
1-888-208-7334
Or, visit us at: www.excellusbcbs.com